



**CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE**

March 15, 2000

**H.R. 1304
Quality Health-Care Coalition Act of 1999**

As introduced on March 25, 1999

SUMMARY

H.R. 1304 would exempt health care professionals from antitrust laws when they negotiate with health plans over fees and other terms of any contract under which they provide health care items or services. Professionals who form coalitions for that purpose would receive the same treatment under antitrust laws that labor organizations receive for collective bargaining activities under the National Labor Relations Act. The Congressional Budget Office (CBO) concludes that under the bill some health professionals, including doctors, dentists, and pharmacists, would join together and negotiate for higher compensation and greater flexibility in the provision of care, thereby increasing private and public expenditures for health care.

The bill would affect both federal revenues and outlays. By increasing costs to private health plans, H.R. 1304 would result in higher private health insurance premiums. In the case of employer-sponsored health plans, higher premium contributions charged to employers would be passed on to employees in the form of lower cash wages and other fringe benefits. Reductions in those taxable forms of compensation would lead to lower federal and state tax revenues. CBO estimates that federal tax revenues would fall by \$145 million in 2001 and by \$10.9 billion over the 2001-2010 period if H.R. 1304 were enacted.

H.R. 1304 would also raise the costs of several federal health programs. Direct spending for the Federal Employees Health Benefits Program (FEHBP), Medicaid, and the State Children's Health Insurance Program (SCHIP) would grow by an estimated \$165 million in 2001 and by \$11.3 billion over the 2001-2010 period. Discretionary spending by federal agencies for the FEHBP would increase by another \$0.5 billion over ten years. Other federal programs could also be affected, but CBO has not yet completed estimates of those effects.

The bill contains an intergovernmental mandate as defined by the Unfunded Mandates Reform Act (UMRA), but CBO estimates that it would impose no significant costs. Thus, its costs would not exceed the threshold established in that act (\$55 million in 2000). However, state, local, and tribal governments would face higher expenses as purchasers of health care for their employees and as providers of health care under Medicaid, and they would realize lower income tax collections because taxable income would be lower. The bill contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 1304 is shown in Table 1. The bill would add to discretionary spending by all federal agencies for employee health benefits and would affect mandatory spending in budget function 550 (health). It would also reduce federal revenues.

BASIS OF ESTIMATE

Under the bill, some health professionals would join together to negotiate for higher compensation and greater flexibility in the provision of care. CBO assumes that it would take five years for the bill to have its full effect on the health care market. Once that effect was obtained, CBO estimates that H.R. 1304 would increase national expenditures on private health insurance by 2.6 percent in 2006 in the absence of any compensating changes on the part of health plans or other entities.

Allowing health care professionals to bargain collectively with health plans would result in higher health care expenditures for two reasons. First, the increased market power achieved by providers who could form and maintain effective coalitions would allow them to obtain higher fees from the health plans. Second, the greater flexibility that health professionals would obtain in the provision of care would lead to greater utilization of services.

Effect on Fees for Health Care

For the purposes of this estimate, health care professionals are separated into three categories: physicians, dentists and other health care professionals, and pharmacists. Based on projections of national health expenditures for 2000, private health insurance spending for physicians will equal an estimated \$128 billion, spending for dentists and other health

professionals will total \$53 billion, and spending for prescription drugs and related items will be \$59 billion.

TABLE 1. ESTIMATE OF THE BUDGETARY EFFECTS OF H.R. 1304,
THE QUALITY HEALTH-CARE ACT

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
REVENUES											
On-Budget: Income and Medicare Payroll Taxes	0	-100	-260	-430	-620	-840	-950	-1,000	-1,060	-1,120	-1,190
Off-Budget: Social Security Payroll Taxes	0	-45	-110	-190	-280	-370	-420	-440	-470	-490	-520
Total	0	-145	-370	-620	-900	-1,210	-1,370	-1,440	-1,530	-1,610	-1,710
DIRECT SPENDING											
Federal Employee Health Benefits for Annuitants	0	5	10	20	25	35	40	40	45	50	50
Medicaid	0	150	330	550	805	1,110	1,220	1,340	1,475	1,620	1,780
SCHIP	0	10	20	40	60	75	75	80	85	90	100
Total	0	165	360	610	890	1,220	1,335	1,460	1,605	1,760	1,930
SPENDING SUBJECT TO APPROPRIATION ACTION											
Federal Employee Health Benefits for Active Workers	0	10	20	30	45	60	65	65	70	75	80
Indian Health Service	Not Yet Estimated										
Tricare (Department of Defense)	Not Yet Estimated										
Other Federal Health Programs	Not Yet Estimated										

NOTE: SCHIP = State Children's Health Insurance Program.

Physicians. The effect on health care costs of allowing physicians to form coalitions to bargain with health plans would depend on the gain obtained by each physician joining a coalition and the number of physicians who would join.

Based on studies of the effects of unionization on the compensation of employees, CBO estimates that, on average, doctors who join an effective coalition would secure an increase in fees averaging 15 percent. Only a fraction of all physicians would become members of such coalitions, however.

Currently 20 percent of physicians are nonsupervisory employees of a health organization and, therefore, are already eligible to form a union. (They would not be directly affected by the bill.) Of those approximately 100,000 physicians, about 40 percent are either members of unions or covered by a collective bargaining agreement. CBO expects that fraction to grow over the next several years.

Of the approximately 400,000 practicing physicians who would be newly eligible to form a coalition under the bill, CBO estimates that about one-third would join an effective coalition within five years. (In addition, some physicians who did not join an effective coalition would benefit from negotiated increases in fees.) Together with the growing fraction of employee-physicians who are expected to be union members, we estimate that under the bill almost 40 percent of physicians would be union or coalition members by 2006.

About 30 percent of all physicians would join effective coalitions because of the legislation. Assuming a 15 percent average increase in fees, total physician fees would rise by about 4.5 percent. Because physicians represent about one-third of insured national health expenditures, CBO estimates that the effect of newly eligible physicians joining those coalitions under H.R. 1304 would be to increase total private health insurance expenditures by 1.6 percent in 2006.

Dentists and Other Health Professionals. Like physicians, dentists and other health professionals who join an effective coalition under the bill would obtain higher fees from health plans. CBO assumes that those health professionals would secure the same 15 percent average increase in fees if they were able to form effective coalitions. However, CBO expects that the fraction of dentists and other health professionals who would maintain an effective coalition would be lower than the proportion of participating physicians. Also, dentists and other health professionals account for a much smaller percentage of private health expenditures than do physicians. As a result, CBO estimates that higher fees for dentists and other health professionals would increase private health expenditures by about 0.3 percent in 2006.

Pharmacists. H.R. 1304 would also make pharmacists eligible to form a coalition to negotiate with health plans over the net margins received for filling prescriptions. CBO assumes that pharmacists who could maintain an effective coalition would have the same bargaining power as other health professionals. Thus, on average, they would be able to negotiate an average increase of 15 percent in their net margins. CBO expects that about one-third of pharmacists would join an effective coalition. CBO estimates that higher fees paid to pharmacists as a result of H.R. 1304 would increase private health insurance expenditures by 0.1 percent.

Effect on Health Care Utilization

Health care professionals who formed an effective coalition under the bill would also be likely to bargain with managed care plans for greater flexibility in the provision of care. Those plans control costs to a certain extent by regulating the quantity of services performed. Not all managed care plans limit the use of services to the same extent, however. Preferred provider organizations (PPOs), for example, control costs by negotiating discounts on the prices of services and exercise very little management over the use of services. Health maintenance organizations (HMOs), in contrast, often have tighter utilization controls.

Negotiations allowed under the bill would weaken the utilization management controls used by some plans. Fee-for-service plans and PPOs would not be directly affected because they have extremely limited utilization controls. Group- and staff-model HMOs would also be unlikely to be significantly affected because the physician groups that work in those types of HMOs have a long history of less costly practice styles, exemplified by lower rates of hospitalization. Also, physicians who are employees of HMOs can already unionize under current law so any behavior they might undertake to increase utilization would not be a direct result of H.R. 1304.

In contrast, other forms of HMOs and point-of-service plans tend to be staffed by independently practicing doctors who are less integrated into the organization. Those plans have brought about utilization savings through various forms of financial incentives and administrative requirements. Such control mechanisms could be partly dismantled as the result of collective negotiations by the physicians that staff such network plans. For those plans, utilization management now yields about a 5 percent savings compared to indemnity insurance. CBO estimates that 50 percent of the utilization savings associated with coalition physicians who contract with those managed care plans would be lost as a result of the bill. This increase in utilization by coalition physicians would raise private health expenditures by 0.3 percent.

While CBO believes that professionals who form coalitions would gain the most flexibility under this bill, the utilization effect might not be limited to health professionals who are members of a coalition. If professionals in coalitions changed the way they practice medicine, that would affect conventions of medical practice more generally. That is, the changes in the way those professionals practice their trade could spill over to the rest of the physician population. The presence of this effect is based on evidence that physicians usually adhere to the norms of practice established by their peers. CBO expects that such changes in professional practice would only increase utilization by about one-fifth of the increase in utilization that would occur in managed care plans whose utilization controls would be weakened through negotiation. This spillover effect would raise private health expenditures covered by insurance by an additional 0.3 percent.

Effect on Federal Revenues and Direct Spending

H.R. 1304 would reduce federal revenues and increase direct spending (see Table 1). By increasing premiums for employer-sponsored health benefits, it would substitute nontaxable employer-paid premiums for taxable wages and would therefore decrease federal income and payroll tax revenues. CBO estimates that the bill would reduce federal tax revenues by \$145 million in 2001 and by \$10.9 billion over the 2001-2010 period. Social Security tax revenues, which are off-budget, account for about 30 percent of those totals.

The legislation would impose additional costs on several federal health programs because they would be subject to similar price and utilization pressures. CBO has completed preliminary estimates of the effects on the Federal Employees' Health Benefits Program, Medicaid, and the State Children's Health Insurance Program (SCHIP). CBO estimates the bill would not have a significant effect on spending by Medicare because Medicare's administered pricing systems insulate the program from pricing changes in the private sector. CBO expects the proposal would also increase spending by the Indian Health Service, Tricare, and other federal health programs, but has not completed estimates of those effects.

CBO estimates H.R. 1304 would increase direct spending by FEHBP (for annuitants), Medicaid, and SCHIP by \$165 million in 2001 and by \$11.3 billion over the 2001-2010 period. Assuming appropriation of the necessary amounts, CBO estimates the proposal would increase discretionary spending by federal agencies for the FEHBP for active workers by \$10 million in 2001 and \$0.5 billion over ten years. CBO has not completed estimates of the effect on discretionary spending for other federal health programs.

PAY-AS-YOU-GO CONSIDERATIONS

Because the bill would affect federal revenues and direct spending, pay-as-you-go procedures would apply. The direct spending and revenue effects are shown in Table 1. For pay-as-you-go purposes, only the effects in the current year, the budget year, and the succeeding four years are counted.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 1304 contains an intergovernmental mandate as defined by UMRA, but CBO estimates it would not impose significant costs on state, local, or tribal governments. By exempting health care professionals from certain antitrust laws, the bill would preempt state laws that govern similar exemptions under current law, and therefore would be a mandate as defined by UMRA. However, because the bill would not require states to take action as regulators in order to comply with the new exemption, and in some cases might reduce oversight responsibilities, CBO estimates the mandate itself would impose no costs on state, local or tribal governments.

State, local, and tribal governments would experience an increase in premiums for health insurance for their employees and would also incur an increase in Medicaid costs. State expenditures for Medicaid and SCHIP would increase by \$120 million in 2001 and by \$2.3 billion over the 2001-2005 period. At present, CBO cannot estimate the likely increase in the cost of health insurance for employees of state, local, and tribal governments.

Most states that tax income use the federal adjusted gross income measure as the basis of their tax calculations. Consequently, substituting non-taxable income for taxable income for federal income tax purposes would have the effect of decreasing state income tax collections as well.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains no private-sector mandates as defined in UMRA.

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